THE UNIVERSITY OF CHICAGO
THE PRITZKER SCHOOL OF MEDICINE

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Attention:
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Re: George Bynam

Dear Ms Sulpizio:

Please find my report regarding my opinions on this case below.

1. I am a physician, duly licensed to practice medicine in the State of Illinois. I am Board Certified in Medical Oncology and practice in the fields of Medical Oncology with a subspecialty in Gastrointestinal Oncology, including patients with esophageal squamous cancer. I have been involved in these patients' care including various therapies such as in the perioperative and metastatic settings.

2. I have reviewed information and records regarding this case, including the records of Dr. Chockalingham, SCDC, and SCOA.

3. Mr. George Bynam was a man incarcerated at SCDC (South Carolina Department of Corrections). He began complaining of dysphagia (food getting stuck, problems swallowing) in July 2014. Eventually after long delay, he had an upper endoscopy (EGD -esophagogastroduodenoscopy) to evaluate his symptoms on 12/12/14 ~5 months after initial presentation of symptoms. Per report, he had evidence of esophagitis (inflammation of the esophagus), Schatzki's ring, and hiatal hernia. Biopsy results from this procedure revealed Barrett's Esophagus (a premalignant condition) but no cancer, and no dysphagia ("pre-cancer"). The patient continued to complain of dysphagia and odynophagia (pain with swallowing) despite prescription of antacids and soft diet. Given these persistent complaints, a repeat EGD was performed on 8/11/15, about 8 months later. Again this demonstrated, per report,

esophagitis with hiatal hernia and Barrett's esophagus, but on biopsy negative for dysplasia or cancer. He had continued progressive dysphagia after this and again had a repeat third EGD on 5/13/16, now 17 months from the first EGD and 9 months from the last. Unfortunately on this scope a mass was found 28cm-35cm in the mid-esophagus and biopsy demonstrated focally dysplastic squamous epithelium. Eventually he was seen at MUSC and repeat EGD with endoscopic ultrasound (EUS) on 6/30/16 demonstrated a T2N1 lesion, and a PET scan was performed on 8/3/18 which revealed metastatic lymph nodes (supraclavicular and mediastinal) outside surgical field, and therefore deemed stage IV and unresectable.

4. The patient was treated with chemoradiotherapy with carboplatin/paclitaxel and RT from 9/15/16-10/19/16. A PET scan 12/13/16 demonstrated minimally active mediastinal nodes and stable disease. However, a restaging CT scan done 6/23/17 demonstrated new left lower lobe lung lesion and another in the lingual of the lung that was suspicious for metastatic disease. A PET scan 7/7/17 also demonstrated active lung nodules. The patient decided to not do palliative chemotherapy and was referred to hospice.

5. The five year survival of Stage IV esophageal cancer is approximately 5% or less, with or without optimal palliative therapy.

6. It is my opinion, with a reasonable degree of medical certainty, that the cancer of the esophagus was present prior to being ultimately identified on the third EGD on 5/13/16, since at that time it was already stage IV to metastatic distant lymph nodes. It is likely that it was present at the time of the second endoscopy on 8/11/15, and probably more likely than not present on the initial EGD on 12/12/14.

7. It is my opinion, that should an esophageal cancer been identified on the first endoscopy, 17 months prior to the ultimate date of identification, the stage of the cancer would have been more favorable and likely localized without even regional lymph node metastases. The 5 year survival with optimal chemoradiotherapy +/- surgery is approximately 43% in this scenario.

8. It is my opinion, that should an esophageal cancer been identified on the second endoscopy, 9 months prior to the ultimate date of identification, the stage of the cancer would have been more favorable and likely locally advanced with regional lymph node metastases. The 5 year survival with optimal chemoradiotherapy +/- surgery is approximately 23% in this scenario.

9. In summary, should this esophageal cancer have been identified earlier at the time points above, the patient would have had improved survivability of his cancer. By the time it was ultimately discovered, it was already stage IV and all therapy was palliative.

Best Regards,

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